

Varicella (Chickenpox) Disease Surveillance Line Listing (Outbreak Situation)

County: _____ City: _____ Cases: _____ School / Daycare / Provider: _____

Report all cases of chickenpox, including those reported by parent via telephone (please ask about vaccination history and severity of lesions).

Name of Case	Date of Birth	Date of Rash Onset	Varicella Vaccination	Vaccination Date(s)	Severity of Disease*
			<input type="checkbox"/> Yes <input type="checkbox"/> No	#1___/___/___ #2 ___/___/___	<input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III
			<input type="checkbox"/> Yes <input type="checkbox"/> No	#1___/___/___ #2 ___/___/___	<input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III
			<input type="checkbox"/> Yes <input type="checkbox"/> No	#1___/___/___ #2 ___/___/___	<input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III
			<input type="checkbox"/> Yes <input type="checkbox"/> No	#1___/___/___ #2 ___/___/___	<input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III
			<input type="checkbox"/> Yes <input type="checkbox"/> No	#1___/___/___ #2 ___/___/___	<input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III
			<input type="checkbox"/> Yes <input type="checkbox"/> No	#1___/___/___ #2 ___/___/___	<input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III
			<input type="checkbox"/> Yes <input type="checkbox"/> No	#1___/___/___ #2 ___/___/___	<input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III
			<input type="checkbox"/> Yes <input type="checkbox"/> No	#1___/___/___ #2 ___/___/___	<input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III
			<input type="checkbox"/> Yes <input type="checkbox"/> No	#1___/___/___ #2 ___/___/___	<input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III
			<input type="checkbox"/> Yes <input type="checkbox"/> No	#1___/___/___ #2 ___/___/___	<input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III
			<input type="checkbox"/> Yes <input type="checkbox"/> No	#1___/___/___ #2 ___/___/___	<input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III
			<input type="checkbox"/> Yes <input type="checkbox"/> No	#1___/___/___ #2 ___/___/___	<input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III
			<input type="checkbox"/> Yes <input type="checkbox"/> No	#1___/___/___ #2 ___/___/___	<input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III
			<input type="checkbox"/> Yes <input type="checkbox"/> No	#1___/___/___ #2 ___/___/___	<input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III

Name of Person Submitting Report: _____ Date of Report: _____

*Severity of Disease: Estimate the number of chickenpox lesions/spots easily counted by parent or nurse

I – 50 spots or less, easily counted within 30 seconds II – 50-500 spots III - >500 spots or spots clumped so closely together that little normal skin is visible